Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Berry, a prisoner at HMP Humber, on 21 October 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

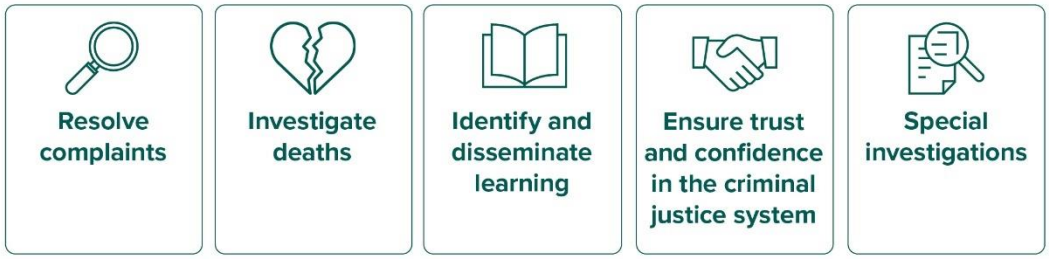
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Scott Berry died in hospital on 21 October 2023, nine days after he was found unresponsive with a ligature tied around his neck in his cell at HMP Humber. He was 37 years old. I offer my condolences to Mr Berry's family and friends.

Mr Berry was the third prisoner to take their own life at Humber in three years.

Mr Berry was given an Imprisonment for Public Protection (IPP) sentence in 2008, with a tariff (minimum term) of two years and four months. By the time of his death, he was more than 12 years over tariff. He became increasingly frustrated about the length of time he had spent in prison and despondent about his chances of ever being released. This led to a decline in his mental health and ultimately in him taking his own life.

We found that Mr Berry was well-supported by both prison and healthcare staff at Humber. However, there was little that staff could do to address Mr Berry's underlying frustrations about his IPP status and his sense of hopelessness about his future.

In its report on IPP sentences published in September 2022, the Justice Select Committee found that the psychological harm caused by IPP sentences is a considerable barrier to progression for some IPP prisoners and that the indefinite nature of the sentence has contributed to hopelessness and despair that has resulted in high levels of self-harm and some suicides. In September 2023, following a worrying increase in the self-inflicted deaths of IPP prisoners in 2022, I issued a Learning Lessons bulletin on the subject. Recent Ministry of Justice statistics show that the majority of unreleased IPP prisoners have, like Mr Berry, been in prison more than a decade beyond their tariff. Their frustrations are understandable and, of course, the risk is that more IPP prisoners will take their own lives unless action is taken to support them through to release.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **June 2024**

Contents

Summary

Events

1. In October 2008, Mr Scott Berry was convicted of robbery and was given an Imprisonment for Public Protection (IPP) sentence, with a tariff (minimum term) of two years and four months. (An IPP prisoner must serve their tariff before they can be considered for release by the Parole Board.)

2. Mr Berry had a history of mental illness, a range of personality disorders, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD) and learning difficulties. He also had a history of substance misuse.

3. In July 2011, following a parole review, Mr Berry was moved to an open prison. However, three months later he was moved back to closed conditions due to suspicions that he was bringing drugs into the prison.

4. Between 2012 and 2017, Mr Berry had four parole reviews. Each time, the Parole Board decided that Mr Berry was not ready for release or a move to open conditions.

5. In July 2018, after a deterioration in his mental health, Mr Berry was moved to a secure hospital. He returned to prison three months later. At his next parole review in March 2020, the Parole Board found that Mr Berry had made good progress but needed more time to demonstrate that he was ready for release or a move to open conditions.

6. Mr Berry was moved to HMP Humber on 17 July 2020. This was a progressive move to a special unit offering additional support to IPP prisoners, known as the Hope Unit.

7. Mr Berry initially made good progress in the Hope Unit and was appropriately supported. He gained employment as a cleaner and often received positive behaviour entries about his work and attitude. He regularly took mandatory drug tests which were always negative. However, he later became more confrontational towards staff and started to receive negative behaviour entries. He complained frequently about his IPP sentence and became anxious about upcoming parole reviews.

8. In May 2022, Mr Berry assaulted a member of staff and was removed from the Hope Unit.

9. In October 2022, Mr Berry and another prisoner staged a protest about IPP sentences, threatening to harm themselves if staff approached them.

10. In June 2023, after the Parole Board again decided that Mr Berry was not suitable for release or a move to open conditions, he self-harmed by hitting himself. He later started a short period of food refusal, protesting about his IPP status. Around this time, he began to refuse mandatory drug tests and told staff he was using psychoactive substances (PS – also known as Spice). He refused support from the substance misuse service.

11. Staff started ACCT monitoring on 1 September 2023, after Mr Berry self-harmed by hitting himself and made statements that he would be better off dead. He later told staff that he did not want to die but was just frustrated about how long he had been in prison. Staff stopped ACCT monitoring the following day and had no concerns about him at the time of his ACCT post-closure review eight days later. He moved back to the Hope Unit on 20 September.

12. On 12 October, which was Mr Berry's late father's birthday, staff restarted ACCT monitoring after Mr Berry said he was feeling suicidal. Staff checked on him four times an hour. At 6.54pm, an officer carrying out an ACCT check on Mr Berry saw that he was hanging by a ligature at the window. He immediately radioed a code blue (an emergency code which tells the control room that a prisoner is unresponsive or not breathing and an ambulance is required immediately) and went into the cell. Other staff arrived, cut down Mr Berry and started CPR. Healthcare staff arrived shortly afterwards and took over CPR. Paramedics arrived and were able to resuscitate Mr Berry and take him to hospital. However, Mr Berry died in hospital on 21 October.

Findings

13. Staff managed Mr Berry's risk of suicide and self-harm appropriately. They held multidisciplinary ACCT reviews attended by those who had a good knowledge of Mr Berry's complex mental health issues.

14. Overall, we found that Mr Berry received a good standard of care and support from prison and healthcare staff during his time in prison and, specifically, at Humber. However, Mr Berry became increasingly frustrated about the length of time he had spent in prison and despondent about his chances of ever being released. When he died, he was over 12 years beyond his tariff with no imminent prospect of release. There was very little staff could do to address the underlying reasons for Mr Berry's frustration and distress, given this was due to his IPP status over which prison staff had no control.

15. HMPPS published an IPP Action Plan in April 2023, in response to the Justice Select Committee's report on IPP sentences. It sets out a commitment to improve the prospects of progression through the IPP sentence and includes a requirement for Executive Directors to introduce IPP Delivery Plans by the end of April 2024. These need to include meaningful actions to support IPP prisoners through to release if we are to stop seeing IPP prisoners taking their own lives out of frustration and desperation at their situation.

16. We make no recommendations.

The Investigation Process

17. HMPPS notified us of Mr Berry's death on 21 October 2023.

18. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

19. The investigator obtained copies of relevant extracts from Mr Berry's prison and medical records.

20. NHS England commissioned an independent clinical reviewer to review Mr Berry's clinical care at the prison.

21. The investigator and clinical reviewer jointly interviewed seven members of staff in February and March 2024.

22. We informed HM Coroner for Hull of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

23. The Ombudsman's family liaison officer wrote to Mr Berry's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Berry's mother did not have any specific questions but was concerned about her son's mental health. We have addressed this in the report and in the clinical review.

24. We shared our initial report with Mr Berry's mother. She did not raise any factual inaccuracies.

25. We shared our initial report with the Prison Service. The Prison service did not raise any factual inaccuracies with our report.

Background Information

HMP Humber

19. HMP Humber is a large category C resettlement prison in East Yorkshire. Primary healthcare is provided by Spectrum Community Health CIC and mental health care is provided by Tees, Esk and Wear Valleys NHS Foundation Trust.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Humber was a scrutiny visit in November 2020, during the pandemic. Inspectors found that managers, staff and prisoners had responded well to the pandemic and continued to maintain an environment safe from COVID-19.

21. Inspectors acknowledged the important additional support provided to some of the indeterminate-sentenced prisoners in the Hope Unit but noted that the restricted regime at the time made it difficult for such prisoners to demonstrate any significant progress.

22. Inspectors found that only 37% of prisoners who had been managed under suicide and self-harm prevention procedures said that they felt cared for by staff, but that this was at odds with most of the documentation they reviewed and the generally positive feedback they received from prisoners during their visit.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to December 2022, the IMB reported that HMP Humber had continued to be a safe place for prisoners and extremely well-managed throughout the pandemic. The Governor and senior management team appeared to have given all possible consideration to moving forward in their planning of a revised alternative regime in order to maintain the safety of everyone within the establishment while trying to attain a high level of purposeful activity for prisoners. There had been an overall reduction in self-harm, prisoner-on-prisoner violence and prisoner-on-staff violence.

Previous deaths at HMP Humber

24. Mr Berry was the tenth prisoner to die at Humber since October 2020. Of the previous deaths, two were self-inflicted and seven were due to natural causes. There are no similarities between Mr Berry's death and the previous deaths at Humber.

Imprisonment for Public Protection (IPP) sentences

25. Imprisonment for Public Protection (IPP) sentences were introduced in 2005. They were intended for high-risk prisoners who were considered dangerous, but whose offences did not merit a life sentence. Those sentenced to an IPP sentence were set a minimum term (tariff) which they had to spend in prison before the Parole Board could consider them for release. The Parole Board will direct release only if the prisoner has demonstrated that they have sufficiently reduced their risk to a level that can be managed in the community.

26. The imposition of IPP sentences was abolished in 2012 due to the inconsistent and more frequent application of these sentences than was intended. However, as of 31 December 2023 there were still 1,227 unreleased IPP prisoners in England and Wales. The majority, 58%, had been held for at least ten years beyond the end of their minimum term. In addition, there were 1,625 recalled IPP prisoners in custody, making a total IPP prisoner population of 2,852.

27. Data from the Ministry of Justice (MOJ) shows that in 2022 there were nine self-inflicted deaths of IPP prisoners, the highest number of self-inflicted deaths among the IPP prison population since the sentence was introduced.

28. In September 2022, the Justice Select Committee (JSC) published a report of its review of IPP sentences. The JSC found that the indefinite nature of the sentence contributed to feelings of hopelessness and despair that had resulted in high levels of self-harm and some suicides within the IPP population. They recommended that all IPP prisoners should be re-sentenced.

29. In February 2023, the Government announced that it would not re-sentence IPP prisoners. In response to the JSC report, the MOJ and HMPPS published a new IPP Action Plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to “maximise their prospects of achieving a safe and sustainable release”.

30. In September 2023, we issued a Learning Lessons Bulletin on the self-inflicted deaths of IPP prisoners. We concluded that an IPP sentence should be considered as a potential risk factor for suicide and self-harm. We also identified a number of risk triggers associated with IPP prisoners including parole hearings, prison transfers and change in security categorisation.

Key Events

28. In October 2008, Mr Scott Berry was convicted of robbery and given an Imprisonment for Public Protection (IPP) sentence, with a tariff (minimum term) of two years and four months. (IPP prisoners must serve their tariff before they can be considered for release by the Parole Board. The Parole Board will only direct the prisoner's release if they are satisfied that they no longer pose a risk to the public. The Parole Board can also recommend a move from closed to open conditions in order to prepare for release.)

29. Mr Berry had a history of mental illness, a range of personality disorders, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and learning disabilities. Mr Berry also had a history of substance misuse.

30. In June 2011, following his first parole review, Mr Berry was moved to HMP Hatfield, a Category D open prison. This was a progressive move towards his eventual release from custody. However, just three months later, Mr Berry was returned to closed conditions at HMP Moorland due to suspicion that he had been involved in bringing drugs into Hatfield, which he denied.

31. Following his return to Moorland in September 2011, Mr Berry suffered a decline in his mental health. He said he was hearing voices, and he began self-harming by cutting his arms. Staff started suicide and self-harm prevention procedures (known as ACCT). There followed a period of instability for Mr Berry when staff were regularly managing him under ACCT procedures to keep him safe. During this time, he spoke to staff about the trauma he experienced when, aged 14, he found his father dead. He understood that he struggled to manage his emotions, often resorting to using drugs and alcohol to cope.

32. In June 2012, and again in July 2014, the Parole Board decided that Mr Berry was not suitable for release or a move to open conditions.

33. In August 2014, Mr Berry was moved to a special personality disorder unit at HMP Garth. However, he was returned to Moorland in December 2015 due to limited motivation, unusual behaviour and continued substance misuse.

34. Mr Berry had two further parole reviews in October 2015 and March 2017. Both times, the Parole Board considered that Mr Berry was not suitable for release or a move to open conditions.

35. Mr Berry's mental health continued to deteriorate and in July 2018, he was moved to the Humber Centre, a medium secure hospital, under Section 47/49 of the Mental Health Act. However, he was sent back to prison just three months later in October 2018. Staff were reportedly unable to manage his behaviour and recommended he should be assessed for personality disorder services at Rampton Secure Hospital. He was subsequently assessed for this service and deemed unsuitable.

36. Following his discharge from the Humber Centre, Mr Berry was sent to HMP Hull. Records show that he complied with his medication, abstained from using drugs, adhered to the prison regime, and gained employment. He also stopped self-harming.

37. At his next parole review in March 2020, the Parole Board commended him on his good progress but considered that he needed more time to demonstrate that he was suitable for release or a move to open conditions.

HMP Humber

38. Mr Berry was moved to HMP Humber on 17 July 2020. This was a progressive move suggested during his last parole review. Mr Berry was placed in the Hope Unit, a special unit providing additional support to IPP prisoners.

39. Mr Berry initially made good progress in the Hope Unit and was appropriately supported. He gained employment as a cleaner and often received positive behaviour entries about his work and general attitude towards staff and others. He engaged on a regular basis with his key worker, psychologist and mental health team. Mr Berry openly spoke about his past trauma, including finding his father dead, and also expressed his fears of losing loved ones while he was still in prison. He said that he struggled to cope around the anniversaries of the deaths of family members. Staff supported him around these times by providing distraction packs and allowing him to light a candle in the chapel.

2021

40. From February 2021, Mr Berry began to display poor behaviour towards staff and accumulated six negative behaviour entries on his record as the year progressed. Records show that he frequently expressed frustration about his IPP sentence and uncertainty about his next parole review. Despite this, his behaviour overall remained manageable and the positive behaviour entries continued to outweigh the negative.

41. On the evening of 21 December, Mr Berry's mother called the prison to say she was concerned about his mental health after a telephone conversation she had with him. Staff started ACCT monitoring the next day after Mr Berry self-harmed by hitting himself in his face and head, which required hospital treatment. He said that he was hearing voices telling him to harm himself. This was Mr Berry's first incident of self-harm since 2018. Following a medication review, staff stopped ACCT monitoring on 23 December.

2022

42. On 13 February 2022, Mr Berry told his key worker that he was frustrated that he did not have a date for his parole review. He said that 14 years was too long to be in prison, and he needed to go home. Later that day he was told that a psychological report had been ordered for his next parole review.

43. A psychologist met with Mr Berry on 15 and 21 March to prepare his psychology report for the Parole Board. She said that he engaged well with the process.

44. On 21 March, Mr Berry was removed from his job as a reception orderly after he argued with a member of staff and challenged her to sack him, which she then did. Mr Berry's mother called the prison later asking for a welfare check on her son as she was worried about the impact of him losing his job. Staff tried to talk to Mr Berry

later to discuss the possibility of reinstatement to his job which he had successfully held for over a year. However, Mr Berry refused to talk to staff and said he did not want his job back.

45. On 24 May, Mr Berry told a psychologist that he was worried about how his behaviour and mental health issues might affect his chances of being released. He told her about previous trauma when he was restrained in a secure hospital, saying that this can cause him to lash out if someone forcibly touches him. The psychologist noted that Mr Berry had possible fears about being released, which was being recommended by those providing input into his upcoming parole review.

46. On 29 May, Mr Berry assaulted a member of staff after he reprimanded him for playing his music too loudly. Mr Berry alleged that the member of staff grabbed him which caused him to react. When staff later went to Mr Berry's cell to talk to him, he put a razor blade in his mouth and threatened to kill himself. Staff started ACCT monitoring.

47. At his ACCT review on 30 May, Mr Berry acknowledged that he could no longer remain on Hope Unit, and he understood he would face criminal charges for the assault. He told staff that he knew he had messed up his chances of parole and had tried to apologise but he said the officer did not want to accept his apology. Staff told him that he could work towards a return to the Hope Unit in the future. Staff stopped ACCT monitoring on 3 June. By the time of the post-closure review on 11 June, Mr Berry said he was fine but felt he had let down himself and his family.

48. Staff started ACCT monitoring again on 16 June after Mr Berry punched himself in his face and said he was hearing voices. He said that his mental health was suffering as his antipsychotic medication had been reduced due to a problem with his heart. At his first ACCT review, he said he was upset for a number of reasons - losing his job, moving from the Hope Unit, the staff assault, and a recent death in custody. He said he felt safe and settled on the new wing but wanted to get back to the Hope Unit as soon as possible. He also wanted to get another job. Mr Berry said that he was continuing to struggle, had trouble sleeping, and felt that his IPP sentence was affecting his mental health. Staff continued to monitor him under ACCT procedures until 28 June when his mental health appeared more stable, and he said he had no further thoughts of self-harm. Staff told Mr Berry that he would be considered for a return to the Hope Unit if he maintained three months of positive behaviour.

49. On 30 August, staff started ACCT monitoring again after Mr Berry self-harmed by hitting himself. He also told a Listener (a peer supporter trained by the Samaritans) that he was going to hang himself. At his first ACCT review he said he was upset that the police were going to charge him with actual bodily harm against the member of staff he assaulted. He was inconsistent about whether he intended to harm himself, saying that this would depend on the outcome of the parole review. Staff offered Mr Berry a return to the Hope Unit, but he declined.

50. On 21 September, the Parole Board deferred Mr Berry's parole decision due to the outstanding police charges and to give him a chance to prove himself. Records indicate that Mr Berry had expected this result and felt positive about working towards release next time.

51. Staff continued to monitor Mr Berry using ACCT procedures until 26 September and noted no concerns at his post-closure review on 3 October.

52. On 8 October, staff started ACCT monitoring again after Mr Berry self-harmed by hitting himself. He said that he had been "stitched up" by staff as he had been suspected of trying to conceal his medication, something which he denied. Staff continued to monitor Mr Berry using ACCT procedures until 14 October.

53. On 18 October, Mr Berry and another IPP prisoner barricaded themselves in a cell and demanded to speak to someone in authority about IPP sentences. They said they would assault any members of staff who tried to get them out and threatened to harm themselves. Staff gained control of the situation and Mr Berry was relocated to the segregation unit where he began a period of food refusal. He told staff that he was feeling depressed, broken and had no hope.

54. On 19 October, staff restarted ACCT monitoring and placed Mr Berry under constant supervision. They moved him from the segregation unit into a safer cell. ACCT records show that Mr Berry was very emotional with a low level of interaction with staff. He was refusing food and medication and admitted to feeling suicidal as he felt the IPP sentence was a death sentence. Staff continued to monitor Mr Berry constantly until 21 October. Staff then continued to monitor him under ACCT procedures with standard observations until 25 November and he made positive progress. By the time of his post-closure review on 4 December, he was settled and working as a wing cleaner.

55. However, on 8 December, he told the psychologist that he would kill himself if he did not get parole. Staff again started ACCT monitoring and Mr Berry repeated what he had told her, but said he had no immediate thoughts of suicide or self-harm.

2023

56. Staff continued to monitor Mr Berry under ACCT procedures until 17 January 2023.

57. On 9 February, staff told Mr Berry that a decision had been made by the Government that IPP prisoners would not be re-sentenced. Mr Berry was disappointed and frustrated at the decision, but staff had no immediate concerns about him.

58. On 23 February, Mr Berry pressed his cell bell and a female officer attended. She noted that he was dancing around in his cell and acting bizarrely. He then exposed his genitals to her. Mr Berry later said he had no recollection of doing this and he was very upset and anxious about what he had done. He was distressed and said he wanted to apologise to her immediately. Later that day, Mr Berry self-harmed by hitting himself and staff restarted ACCT monitoring.

59. On 27 February, Mr Berry again displayed negative behaviour towards staff by disobeying a direct order. He was sanctioned and subsequently removed from his job as a wing cleaner. Mr Berry was still subject to ACCT procedures but refused to talk to staff at his ACCT review. The following day he told a supervising officer (SO) that he had a razor blade in his cell and wanted it removed. He told her he was upset with recent events and disappointed in himself. He said he did not feel able to

talk to staff as he felt his words could be taken out of context or misconstrued. He continued to refuse to attend ACCT reviews.

60. On 4 March, Mr Berry agreed to attend an ACCT review. The multidisciplinary team met beforehand to discuss his case in his absence and they agreed there was a possibility he may be using psychoactive substances (PS – known as Spice) due to the change in his behaviour. When Mr Berry attended the review, he complained that he was spending too much time in his cell and said it was not good for his mental health. Staff reminded him that he had lost his jobs due to negative behaviour and he became abusive and walked out of the meeting. Two days later, Mr Berry self-harmed again by punching himself.

61. On 14 March, Mr Berry attended an ACCT review and admitted to staff that he had been using PS as a means of coping. He said he could stop if he wanted to, and he did not want any support from the substance misuse team. Staff submitted an intelligence report.

62. On 21 March, staff again asked Mr Berry about his drug use as they were concerned that he may also be in debt. He told staff that he got drugs for free as all the other prisoners felt sorry for him. He acknowledged that he would probably be refused parole and it would probably be another two years before he would be considered again. Staff continued to monitor Mr Berry under ACCT procedures until 10 April, and he once again began to make good progress.

63. However, on 6 May, staff found illegally brewed alcohol in Mr Berry's cell. He admitted it was his and was sanctioned.

64. On 11 May, staff started ACCT monitoring again after Mr Berry seemed low in mood after hearing that he would have to wait two years for his next parole review. Although disappointed, staff noted that he handled the news well and did not self-harm. He was looking forward to starting a job as an education orderly. Staff stopped ACCT monitoring on 18 May.

65. On 3 June, staff restarted ACCT monitoring after Mr Berry self-harmed by hitting himself. He had just received news that his parole had been refused and, although not unexpected, he did not take the news well. He also told staff that he was worried about his mother's mental health and his upcoming court case relating to the staff assault. Staff continued to monitor Mr Berry under ACCT procedures until 9 June. Staff noted no concerns at the time of the post-closure review on 16 June.

66. On 8 June, Mr Berry's prison offender manager (POM) met Mr Berry. They discussed the outcome of his parole review and she said she expected he would have 18 months to prove himself and return to the Hope Unit before his next parole review. She also discussed with Mr Berry that he had been sentenced to an additional ten weeks in custody for the assault on a member of staff.

67. On 26 June, Mr Berry met with a bereavement counsellor. Mr Berry said he was feeling more settled and was looking forward to a visit from his family around his birthday in July as he had not seen them since 2019. Records show that Mr Berry had eight further sessions with the bereavement counsellor.

68. On 12 July, Mr Berry refused to provide a sample for a random drug test. He told staff there was no point as it would be positive anyway. He reported low mood and feeling stressed. Mr Berry was sanctioned for refusing to provide the sample and staff submitted a security intelligence report.

69. On 16 July, Mr Berry received a visit from his mother and brother which lifted his mood. He told staff he was hoping for more regular visits.

70. On 23 July, Mr Berry began a period of food refusal but would not say why. Staff suspected it was because he had received some negative behaviour warnings. Staff started a food refusal log. A few days later Mr Berry was seen eating food from other prisoners, so staff discontinued the food refusal log.

71. Mr Berry appeared to settle down and displayed positive behaviour over the next few weeks. On 29 August, his new key worker met with him. She said he was a little concerned about why he had changed key worker, but he was polite towards her. He said he was doing fine but did not want to talk as he had just woken up, so she booked another date to see him.

72. However, on 1 September, staff restarted ACCT monitoring after Mr Berry self-harmed by hitting himself and said he would be better off dead. He told staff that he did not want to die but he was just frustrated about how long he had been in prison. Staff stopped ACCT monitoring the following day and had no concerns about him at the time of his ACCT post-closure review on 10 September.

73. Mr Berry had further sessions with his key worker and his bereavement counsellor and continued to display positive behaviour.

74. On 21 September, Mr Berry was moved back to the Hope Unit.

75. On 28 September, the psychologist met with Mr Berry to discuss additional psychology work he had requested. She told Mr Berry that he would be added to the waiting list, and he accepted this. Later that day, a psychiatrist saw Mr Berry. He told her that he had previously had psychology sessions, but he had not spoken about abuse in his childhood and now wanted to do so. The psychiatrist noted that Mr Berry was low in mood and told her he had done all the courses he could but felt there was no end in sight. He said that no one could help him, and he sometimes thought he would be happier if he took his own life.

76. Mr Berry received negative behaviour entries on 25 September, 10 October and 11 October.

Events of 12 October

77. At around 2.40pm on 12 October, Mr Berry asked a SO if he could speak to a support worker who had been helping him with budgeting. She noted in Mr Berry's record that he said he was feeling low as it was his late father's birthday. He showed her a photograph of his father and she noted that he appeared very emotional. She noted that she provided him with some distraction materials and spent some time with him, but she felt as though he wanted to be alone. She asked him if this was the case and he said yes, so she left the cell and alerted wing staff to be aware of how Mr Berry was feeling.

78. Around 4.00pm, Mr Berry asked an officer to find out from healthcare if he could have his sedative medication. The officer checked this, and healthcare said he could come to collect it. He said that Mr Berry told him he was feeling suicidal, so he took him along to the office to speak to a SO. The SO restarted ACCT monitoring, placing Mr Berry on four observations an hour. The officer said he returned Mr Berry to his cell and asked him if he wanted to go and get his medication, but he said he did not want it. He said he tried to get Mr Berry out of his cell to mix with others, but he said he wanted to be left alone.

79. CCTV shows that the officer checked on Mr Berry at 6.19pm and went into his cell briefly. He said that he asked Mr Berry if he was okay, and he said he was. He then checked Mr Berry through the observation panel at 6.34pm before turning off the lights on the landing. CCTV shows that at 6.54pm, the officer looked through the observation panel and, within approximately ten seconds, talked into his radio before going into the cell. He said that he could see Mr Berry suspended by a ligature near to the window. He immediately used his radio to call a code blue before going into the cell to hold up Mr Berry's body weight while waiting for his colleagues to arrive.

80. Staff attended around one minute later, cut the ligature and started CPR. Healthcare staff arrived around 6.58pm with emergency equipment and took over CPR. Ambulance staff arrived at 7.22pm and were successful in resuscitating Mr Berry and they took him to hospital at around 7.50pm. However, Mr Berry died in hospital on 21 October.

Contact with Mr Berry's family

81. On 12 October, a prison manager contacted Mr Berry's mother by telephone to let her know that her son had been taken to hospital. Mr Berry's mother and other family members arrived at the hospital at around 11.45pm that evening. Mr Berry's family were with him when he died on 21 October. The Prison Service contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

82. A prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

83. The prison posted notices informing other prisoners of Mr Berry's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Berry's death.

Post-mortem report

84. The post-mortem concluded that Mr Berry died from hanging which caused an irreversible hypoxic brain damage. Toxicology results showed the presence of psychoactive substances and cocaine in Mr Berry's body.

Findings

Assessment and management of Mr Berry's risk of suicide

85. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others or from others (Safer Custody)*, sets out the procedures, known as ACCT, that staff must follow if they identify that a prisoner is at risk of suicide or self-harm.

86. Staff supported Mr Berry using ACCT procedures many times during his 15 years in prison. We found that staff at Humber responded appropriately each time he self-harmed or expressed thoughts of suicide. We also found that staff were alert to the triggers that may have affected Mr Berry's risk and, at times, proactively supported him. We are satisfied that ACCT reviews were multidisciplinary, and that Mr Berry's risk was adequately reduced before staff stopped ACCT monitoring.

87. Staff restarted ACCT monitoring on the afternoon of 12 October, around three hours before Mr Berry was found with a ligature around his neck. We are satisfied that staff managed the ACCT appropriately in the short timescale and carried out relevant checks.

Clinical care

88. The clinical reviewer found that the health care provided to Mr Berry was of a good standard and was equivalent to that which he could have expected to receive in the community. He was under the care of the mental health team, saw his key worker regularly and had regular reviews with the consultant psychiatrist. He had an appropriate care plan that was reviewed regularly. He had also been involved with the psychology services and had been referred again shortly before his death.

Substance misuse

89. Mr Berry admitted that he was using illicit drugs in the months before his death and traces of PS and cocaine were found in his body after his death. It is not possible to know how this may have impacted on his decision to take his life. We found that staff attempted to engage Mr Berry in substance misuse support, but he refused this.

IPP sentences

90. Mr Berry was 12 years over his tariff when he died. He became increasingly frustrated about the length of time he had spent in prison and his diminishing hopes of ever being released. While staff gave him a good level of support, there was very little they could do to address the underlying cause of his frustrations, his IPP status.

91. Although the IPP sentence was abolished in 2012, there were still over 1,200 unreleased IPP prisoners in prison at the end of 2023, and 58% of them, like Mr Berry, had been held for over ten years beyond their tariff.

92. In its report on IPP sentences published in September 2022, the Justice Select Committee (JSC) found that "the psychological harm caused by IPP sentences is a considerable barrier to progression for some IPP prisoners. The indefinite nature of the sentence has contributed to feelings of hopelessness and despair that has resulted in high levels of self-harm and some suicides within the IPP population. In addition to this, IPP prisoners distrust the people and services that are necessary to support their progression."

93. The Government responded to the review in February 2023, when they announced that they would not be re-sentencing those currently subject to an IPP sentence. In response to the JSC report, the Ministry of Justice (MOJ) and HMPPS published a new IPP Action Plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to "maximise their prospects of achieving a safe and sustainable release". It includes measures to support those serving IPP sentences and to reduce the risk of suicide and self-harm.

94. The IPP Action Plan includes a requirement for Executive Directors to introduce IPP Delivery Plans for the prisons in their regions by the end of April 2024. It is important that these plans contain meaningful actions to support IPP prisoners through to release and that staff have an awareness of the specific risks that IPP prisoners present in regard to self-harm and suicide, if we are to stop seeing more IPP prisoners taking their own lives.

Good practice

95. We found that Mr Berry was provided with a good level of support from all staff that he engaged with regularly and we were impressed by the level of detail that went into both his prison and healthcare records.

Inquest

96. At the inquest, heard from 9 to 17 October 2025, the jury reached a narrative conclusion: "Mr Berry deliberately chose to suspend himself by a ligature made from a dressing gown cord, but the evidence does not fully explain whether or not he intended that the outcome be fatal."

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100